Privacy and Security Solutions for Interoperable Health Information Exchange – Kansas

Final Implementation Plan Report

Subcontract No.
RTI Project No. 9825

Submitted by:
Kansas HISPC Steering Committee

Submitted to:

Linda Dimitropoulos, Project Director
Privacy and Security Solutions for
Interoperable Health Information Exchange

Research Triangle Institute
P. O. Box 12194
3040 Cornwallis Road
Research Triangle Park, NC 27709-2194

Date: April 16, 2007

RTI INTERNATIONAL

Kansas Implementation Plan Working Group

Judith Warren, Chair	Kansas University Medical Center
Jacque Amspacker	Medical Society of Johnson & Wyandotte Counties
Karen Braman	Kansas Health Policy Authority
William Bruning	Mid-America Coalition on Health Care
Michelle Carter-Gouge	Preferred Health Systems, Inc.
Gary Caruthers	Kansas Medical Society
Helen Connors	Kansas University Medical Center
Linda Davis	KC Care Link
Bryan Dreiling	Dept. of Information Systems & Communications, State of Kansas
Jeff Ellis	Lathrop and Gage
Lisa Foos	Preferred Health Systems, Inc.
Trish Hollingsworth	Kansas Hospital Association
Melissa Hungerford	Kansas Hospital Association
Diana Jarvis	Neurosurgical Associates, P.A.
Jackie John	Great Plains Health Alliance
Tom Johnson	Blue Cross Blue Shield of Kansas
Karl Koob	Kansas University Medical Center
Ron Liebman	Kansas Health Institute
Larrie Ann Lower	Kansas Association of Health Plans
Cindy Luxem	Kansas Health Care Association
Michelle Meier	Kansas Medical Clinic, PA
Sunee Mickle	Kansas Health Institute
Shirley Orr	Kansas Department of Health and Environment
Michael Shipley	Kansas Foundation for Medical Care
Jerry Slaughter	Kansas Medical Society
Greg Smith	Kansas State University
Robert St. Peter	Kansas Health Institute
Jill Straub	Stormont-Vail Healthcare
Chris Tilden	Kansas Department of Health and Environment
Teresa Titus-Howard	Mid-America Coalition on Health Care
Scott Vondemkamp	Blue Cross Blue Shield of Kansas
Victoria Wangia	Kansas University Medical Center

This report was prepared by Judith Warren, Kansas University Medical Center, on behalf of the Kansas Implementation Plan Working Group.

KANSAS
PRIVACY AND SECURITY SOLUTIONS FOR INTEROPERABLE HEALTH INFORMATION EXCHANGE

I. Background (1 page)

A. Describe the purpose and scope of this report

This Implementation Plan Working Group (IPWG) report is the final implementation report produced by the Kansas Privacy and Security Solutions for Interoperable Health Information Exchange Steering Committee (HISPC). The Final Assessment of Variation and Analysis of Solutions report documented the organization and findings of the preliminary reports of the Kansas Variations Working Group (VWG) and Legal Working Group (LWG), whose charge was to identify barriers to health information exchange (HIE) resulting from organization-level business policies and practices, laws and regulations and the organization and findings of the Solutions Work Group (SWG), whose charge was to translate operational issues into strategic opportunities and provide recognizable landmarks to members of the Kansas collaboration as they plan to implement regional health information exchange solutions.

The primary purposes of the IPWG process and this report are to (1) develop an overall implementation plan for the State of Kansas to achieve translation of strategic opportunities and (2) provide a plan to implement the infrastructure to support regional health information exchange solutions. The IPWG used the solutions derived from the SWG to create these implementation strategies.

B. Describe key assumptions, limitations and other background information to lay the foundation for the implementation plans

Implementing HIT/HIE requires collaboration within each stakeholder organization including clinicians, HIT professionals, and administrators. It has proven difficult to ensure all types of expertise are engaged in HISPC. HISPC participants have committed significant time and energy to the process, yet that process is not currently perceived outside the Kansas project membership as having sufficient urgency to draw wider and deeper interest and expertise. Neither the technical nor the strategic findings of the Kansas SWG are fully developed at this time; however, we believe this is an excellent start for future statewide planning and implementation.

Kansas has a few organizations beginning to develop local or regional health information exchanges, but the lack of electronicization by providers is noteworthy. The state itself has sponsored a number of initiatives to help promote HIT and HIE activities. Nevertheless, Kansas like most other states has not yet produced a viable, generalizable HIE process. The broad lack of electronicization offers an opportunity to stakeholders that are beginning the process, seeking best practices, and unencumbered with legacy systems that would have to be replaced by a future state-wide approach.

One benefit of HISPC is the establishment of a strategic plan for conducting demonstration projects, sharing lessons learned, and producing one or more interoperable models for health

information exchange. In this way, we hope to mitigate some risks of investment and promote development of HIE best practices through accretion. Patients are the most apprehensive among all stakeholders about privacy and security; however, providers express concerns about the business case for HIT/HIE and for the integrity and dependability of received electronic information. Successful solutions will be those that gain consumer acceptance and create market demand for new information products and services.

A limitation of the HISPC process was the limited participation of the consumer community. At one level, the composition of the VWG (over 100 individuals) and the quasi-governmental nature of many of the participating organizations contributed a built-in consumer viewpoint for the data collection process. Additionally, the VWG included senior representation from such consumer-focused groups as the AFL-CIO, the Kansas Health Consumer Organization, the Kansas Association for the Medically Underserved, the Kansas Department of Social and Rehabilitative Services, and the Kansas Office of Local and Rural Health. The IPWG further concluded, in retrospect, that most consumers would have been ill-prepared to enter deliberations at this stage. The intent is to vet this plan more widely with stakeholders and consumers and to use the plan to educate the stakeholders and consumers regarding HIE issues.

Governor Sebelius has provided leadership and support for the advancement of HIT and HIE to improve health care quality, safety, and cost-effectiveness. The Governor continues support in her second term. As a part of this commitment, on February 7, 2007 Governor Sebelius appointed a Health Information Exchange Commission. This group is designed to bring providers and stakeholders together to advance the use of information technology in health care. The new Health Information Exchange Commission will include representatives of the provider community, consumers, business community, health plans, government, information technology experts and health policy experts. Two members of HISPC steering committee have been named as co-chairs of this Commission and two other members have been appointed as members of the Commission. This Commission will continue the work of HISPC and other HIT/HIE state efforts.

II. Summary of Analysis of Solutions Report

A. Summarize the solutions identified to be implemented.

The main findings from the Variations and Legal Work Groups were analyzed according to the nine privacy and security domains and summarized into the following categories. This section summarizes the solutions within the summary categories. A detailed listing of the solutions by domain is in Appendix A.

Patient-focused solution strategies: Health care providers in Kansas have no standard or market-dominant method for obtaining informed consent for the use and disclosure of health records. Patient consent practices are incorporated into business, research, and government operations in a genuine effort to comply with the requirements of federal and state laws. Substantial variation exists in the understanding and enforcement of these requirements. The elements of patient-focused solutions include:

- patient education concerning information about one's rights, preparation for granting informed consent, and acquisition of technical skills to navigate and interpret stored information;
- patient identification;
- access to one's own information and the ability to edit some portion thereof;

- patient control over permitted conditions for data disclosure—how much information, to whom, for what purpose, for how long;
- patient notification, accounting and audit of prospective and retrospective data uses and disclosures; and
- patient consent, denial or revocation of consent for specific instances of information use.

The June 2006 NCVHS report on Privacy and Confidentiality in the Nationwide Health Information Network recommended both that, "the method by which personal health information is stored by health care providers should be left to the health care providers," and that, "HHS should assess the desirability and feasibility of allowing individuals to control access to the specific content of their health records." One of Kansas' proposed solutions is to participate in this national discussion.

Business operations-focused solution strategies: Kansas' SWG found the HISPC domain definitions to be heavily influenced by technology, which was problematic because so few of the state's health care providers have experience with electronic health records. Adoption of health information technology is influenced by powerful market forces, regulation, and other activities of the federal government. Strengthening business policies and practices has solutions from every HISPC domain. Some examples are: require a multi-level process for authentication of users of protected health information (PHI); establish varying levels of access to PHI based on user roles; institute best practices among techniques for assigning patient and provider IDs; educate stakeholders on baseline expectations for network level security; establish complete, auditable and reversible revision histories for electronic health records; conduct periodic external audits of information access logs as well as tests of system "hardness" against attempted breaches; and establish administrative and physical security safeguards that meet or exceed the HIPAA security standard.

Legally-focused solution strategies: The LWG concluded that HIPAA is widely misunderstood and even feared, but is actually an enabler rather than a barrier to health information exchange. There was a sense that HIPAA regulations were sometimes used as an excuse to avoid requests for information exchanges that were perceived as burdensome. Most of the state privacy laws and regulations predate HIPAA and do not contemplate widespread electronic data storage and interchange. The LWG felt that Kansas stakeholders had been well served by the State's not having preempted HIPAA. Stakeholders seemed to be unaware or unconcerned about potential legal pitfalls created by this situation. The LWG, or some similar group, will be tasked to undertake (1) developing a consistent and comprehensive statewide interpretation of HIPAA and its interplay with state laws and regulations; (2) identifying state laws and regulations needing revision to bring them into compliance with HIPAA for the purpose of facilitating electronic HIE; (3) lobbying for the creation of safe harbors from federal enforcement of HIPAA violations which would help remove the fear of electronic HIE for providers; and (4) promoting education of providers and consumers about the proper use of HIE.

Regionally-focused solution strategies: Kansas is geographically diverse and one of the most rural states in the country. Demographers classify its western and central counties as "frontier" because they have fewer than 6 inhabitants per square mile. Kansans who live in these counties commonly travel to other states to obtain health care services from the closest concentrations of providers. Kansas' largest urban center enjoys typical urban population densities but straddles our eastern border with Missouri. The Kansas Health Policy Authority is currently analyzing

medical service areas as part of the statewide HIT/HIE Policy Initiative to quantify this effect. Consequently, the success of nearly any health information exchange solution in Kansas will be influenced by its ability to interact with regional partners.

Kansas is preparing for the next phase of several health information exchange initiatives. Kansas hopes to engage Missouri stakeholders in further planning for health information exchange. At meetings with the Chair of the Missouri Governor's technology taskforce, we perceived considerable interest in collaboration.

The IPWG report has refined the above solutions. Please refer to Section IV for a detailed description.

B. Describe success measurements and or other benefits to be derived from these solutions.

The State of Kansas has initiated a number of projects that seek to directly promote the adoption of electronic health information technology and exchange in the public and private sectors. It is anticipated that these projects will provide considerable synergy by being included in the HISPC implementation plan. The Governor's Health Care Cost Containment Commission sponsored a statewide HIT/HIE Policy Initiative with major funding from three health care foundations. This project, facilitated by the *e*Health Initiative Foundation has so far conducted a readiness assessment for health information exchange, several statewide stakeholder meetings, a roadmap for strategic planning, and a six month process whereby four other workgroups (clinical, technical, finance and governance) in addition to the HISPC project, identified issues and solutions related to the development of HIE infrastructure in Kansas. In addition to the broader statewide initiative, the Commission sponsored the Advanced ID Card Technology Project to bring health plans together to develop consensus around standards for advanced technology ID cards.

Additionally, The Kansas Health Policy Authority is currently piloting a Community Health Record including an *e*-prescribing component in the Kansas Medicaid program. There are over 20 pilot sites, including hospital emergency rooms, safety net clinics and local health departments. The purpose of the pilot is to demonstrate the benefits of merging claims data and clinical data into a Web-based, person-centric record.

The Kansas Department of Health and Environment and the Kansas Health Institute have just completed the first phase of an RWJ *InformationLinks* grant project. *InformationLinks* is designed to accelerate innovative and effective use of information technology by state and local public health agencies. Kansas' goal is to conduct two-way information exchange to synchronize data in the Kansas Immunization Registry with insurance claims data in an employer-based regional health information organization.

We also wish to draw attention here to barriers and solutions recognized by the Clinical Workgroup of the statewide HIT/HIE initiative mentioned above that is not specifically focused on privacy and security. This workgroup was charged with identifying barriers to interoperable health information exchange and proposing possible solutions to those barriers. A copy of their final report can be found at http://www.khpa.ks.gov/QandI/default.htm and a summary of the barriers and proposed solutions is included in Appendix B. The Kansas HISPC workgroups and

the HIT/HIE Policy Initiative workgroups share many members. It is our intention to coordinate the recommendations and implementation strategies of the HISPC and other HIE workgroups.

III. Review of State Implementation Planning Process

A. Describe the organization of the State Implementation planning Workgroup, including its charge, leadership, membership and stakeholder representation.

The charge to the IPWG was to organize the solutions identified by the SWG into a single implementation plan. The group also was apprised of new initiatives from the Governor's office to coordinate HIT/HIE work within the State of Kansas. The implementation plan will serve as a guide for stakeholders and any future statewide coordinating efforts. Two state representatives, Rep. Morrison and Rep. Sharp, attended a recent HISPC Steering Committee meeting and pledged to provide their support in assisting to move the implementation efforts forward. These state officials are the Chair and Co-Chair of the state's Technology Committee (responsible for supporting the growth of technology within the state).

Governor Sebelius created the Health Information Exchange (HIE) Commission, a group designed to bring providers and stakeholders together to advance the use of information technology in health care. The HIE Commission will work to advance the recommendations of the HIE workgroups created through the statewide health information technology and health information exchange policy initiative and the HISPC project (See Appendix C for the announcement). Several members of HISPC were appointed to this Commission. The Co-Chairs are Jeff Ellis, Lathrop and Gage—member HISPC Steering Committee and Chair of Legal Variations Work Group and Karen Braman, Preferred Health Systems—member of HISPC Steering Committee. Other members of the Commission that were involved in HISPC include Helen Connors, KU Center for Healthcare Informatics—Chair of HISPC Steering Committee; Jackie John, RN, Great Plains Health Alliance—member of IPWG; and Bob St. Peter, MD, Kansas Health Institute—Project Director of HISPC, member of HISPC Steering Committee and Chair of the Solutions Work Group.

At the November 2006 SWG meeting, the membership of the IPWG was discussed (members are listed on page two of this report). All SWG members present agreed that the best strategy was for the group to become members of the IPWG as teamwork and relationships had already been established and the knowledge of the members was critical to the success of the IPWG. An invitation letter was sent by the IPWG Chairman to all SWG participants to attend the first meeting of the IPWG. The response to this letter was positive, particularly in light of the extremely tight timeframe imposed by the project schedule. We were pleased to note that all respondents to this invitation elected to continue their participation in the project. This continuity has been one of the strengths of the Kansas process.

Seventeen stakeholders attended the first IPWG meeting and six, who were unable to attend, indicated their willingness to contribute through other venues. Provider community attendees included executives from the state hospital association, a hospital network, the state medical society, the state medical group managers association, long term care, an employer coalition, and the state pharmacists association. Government and academia were well represented, as was the

insurance industry, the state quality improvement organization, a safety-net RHIO, and the Chairs of the Steering Committee, VWG, LWG, and SWG.

The limited participation of the consumer community is a lingering concern, but one that will be addressed as we move forward with the implementation plan. At one level, the composition of the VWG (over 100 individuals) and the quasi-governmental nature of many of the participating organizations contributed a built-in consumer viewpoint for the data collection process. Additionally, the VWG included senior representation from such consumer-focused groups as the AFL-CIO, the Kansas Health Consumer Organization, the Kansas Association for the Medically Underserved, the Kansas Department of Social and Rehabilitative Services, and the Kansas Office of Local and Rural Health. The IPWG further concluded, in retrospect, that most consumers would have been ill-prepared to enter deliberations at this stage. Kansas' VWG report had earlier noted that, "The HISPC forms are too complex and cumbersome to be utilized by consumers unrelated to the process, and most scenarios don't pertain to issues that patient / consumers regularly deal with."

B. Briefly describe how the group assessed the feasibility of implementation plans

The SWG report was reviewed by all members. See Appendix A for a summary of the solutions. Based upon a review of the solutions and using a consensus approach, six goals were identified for the plan. Tasks and timelines were then identified for each goal, along with responsible parties, and barriers to implementation. The plan was then reviewed by the IPWG and refined. The six goals are:

1. Establish a statewide coordinating entity to facilitate HIE and continue the work of the HISPC team
2. Coordinate the interpretation of state and federal laws pertaining to the exchange of health information in Kansas
3. Identify healthcare informatics standards and best practices to improve the exchange of health information and monitor the evolution of national platforms.
4. Develop model policies, procedures, and guidelines for the exchange of health information
5. Educate healthcare entities and the public about the benefits and processes of health information exchange
6. Promote implementation of health information exchange

Little work has gone into feasibility and cost analysis at this stage of HISPC activity in Kansas. One of the first tasks of the new HIE Commission will be to conduct feasibility analysis of the implementation plan and to conduct a cost analysis of the selected projects. The Solutions Work Group has recommended several existing pilots as opportunities to conduct both feasibility and cost analysis studies.

The Kansas HISPC project has received no comments or criticism from anyone other than its direct participants. Our posting on the HISPC web site has generated no input. By the same token, given the time constraints under which it has been working, the Kansas project team has been unable to disseminate information to anyone other than its own members. However, several HISPC participants represent professional associations, and these participants from the various parent organizations are communicating with their own memberships. In addition, because the VWG membership was quite large and many members participated in the other

workgroups, considerable consumer input has actually been generated. Participants in the HISPC project have presented at various professional meetings and academic programs and have solicited input regarding the solutions and plan from participants.

C. Describe how implementation plans are organized, prioritized, and presented in this report

Developing specific strategies and budgets is difficult as the HIE Commission is designated by the Governor's office to continue this work was just recently appointed. Therefore, only the broad objectives and tasks are specified in the plan. Since the co-chairs of this Commission have been members of the HISPC Steering Committee, there is a strong commitment to continue this work. Currently, the Commission believes the educational projects identified in the report in Section 4 to be of high priority since the work of conducting the analysis revealed a deficit in knowledge and understanding of the issues of privacy and security in HIE. Education must occur before the rest of the plans can be fully implemented. Also of importance is beginning the work of legal infrastructure modification to accommodate the implementation of HIE in Kansas.

D. Discuss any specific implementation planning methods and/or tools used

No specific planning methods, other than traditional consensus approaches, were used.

IV. State-level Implementation Plans

Implementation plans that can be executed within a single state (i.e., not requiring collaboration of two or more states and not having interstate implications) should be documented in this section.

A. Statewide strategy and coordination

The Final Assessment of Variation and the Analysis of Solutions Report will identify a number of solutions for possible implementation, some of which are likely to be unrelated in terms of resources required and implementation approach. Describe the strategy for overseeing the implementation of a variety of disparate solutions; identify responsible persons, organizations or agencies, staffing and other resources, and timelines

As stated in goals listed above, the Kansas HIE Commission will coordinate HIT/HIE work within the State of Kansas and between other states. The new Health Information Exchange Commission includes representatives of the provider community, consumers, business community, health plans, government, information technology experts and health policy experts. They will take a public/private approach to advancing the use of information technology and ensuring patients' private health information is protected and secure. This group will work to leverage existing resources including other state projects, and seek external funding through public and private entities, Kansas health foundations, and grant writing efforts. The planning timeline is 18 months.

B. Implementation plans for identified solutions

Alternatively, certain solutions may lend themselves to being combined into a multi-solution implementation plan. Whatever the case, it is essential that each implementation plan specified in this report must contain at least the following elements:

The Kansas Implementation Plan is specified in the following multi-solution plan that includes the work breakdown structure (with timeline, predecessors, and responsible persons in parentheses):

1. Establish the Kansas Health Information Exchange (HIE) Commission to advance HIT/HIE in Kansas and continue the work of the HISPC team (Feb. 1—March 30, 2007; no predecessor; Governor's office, HISPC Steering Committee) – Completed.
   1.1. Work with Governor's office and other state agencies to develop and support Kansas HIE Commission (Feb 1—March 30, 2007; no predecessor; HISPC Steering Committee)
      1.1.1. HISPC reports forward to the Commission
      1.1.2. Members of HISPC appointed to the Commission
   1.2. Transition information from the HISPC project to a statewide coordinating entity as well as to health care leaders and stakeholders who can work collaboratively to implement solutions (4/1—27/2007; no predecessor, HISPC Steering Committee)
   1.3. Pursue a variety of funding opportunities to supplement funds allocated by the State of Kansas budget. (5/1/20007; predecessors 1.1 and 1.2; Kansas HIE Commission)
2. Coordinate state and federal laws and regulations regarding HIE in a manner that will enhance the quality and cost effectiveness of health care services by promoting the secure and efficient exchange of health care information. (Mar 30, 2007—Aug. 30, 2008; no predecessors; LWG members, Key Legislators, Kansas HIE Commission)
   2.1. Convene a work group comprised of the leading health care attorneys in the state to develop a consensus interpretation of HIPAA that can be presented to providers in an effort to reduce the fear surrounding compliance with HIE privacy and security requirements. (*Time required: March-August 2007.*)
   2.2. Convene a work group comprised of representatives of the Office of the Kansas Reviser of Statutes, health care attorneys and law students to review Kansas state laws and regulations governing the provision of health care, identify needed updates to bring such laws and regulations into compliance with HIPAA, as a minimum standard for HIE, and coordinate all such laws and regulations to facilitate the use of electronic HIE. (*Time required: March-October 2007.*)
   2.3. Present recommendations of the above work groups to the Kansas Health Policy Authority and work with it to develop a legislative package for presentation to the 2008 Session of the Kansas Legislature to modernize the Kansas statutory scheme with suggested revisions which facilitate and enhance HIE. (*Time required: September 2007-December 2008.*)
   2.4. Convene leading health care attorneys and the Health Policy Authority to work with key legislators to develop a strategy to pass the comprehensive legislative update described in Step 3 above. (*Time required: October 2007-April 2008.*)
   2.5. Engage the leading health care attorneys nationally to lobby for federally developed "safe harbors" that would identify and clarify areas of prosecutorial concern of HIPAA violations so that providers could safely develop institutional practices that avoid prosecution. (*Time required: August 2007-August 2008.*)

2.6. Develop an educational program with the work group of leading health care attorneys, in collaboration with the various provider associations serving the state, to promote the consensus interpretation of HIPAA developed in Step 1 above and to explain updates in laws and regulations developed in Steps 2-4 above.
2.6.1. Provide educational seminars and webinars to providers and others dealing with HIE specifically designed to address the HIE concerns of each group of providers with the objective of promoting HIE in their daily operations.
2.6.2. Develop a consumer education program through the Kansas Health Policy Authority designed to inform the consuming public regarding the legal use of HIE and the public's rights to privacy and security of their health information with the objective of reducing the public's fear of HIE and promoting the advantages to be gained in efficiency, convenience, quality, and safety of the health care system.

3. Identify healthcare informatics standards and best practices to improve the exchange of health information (May 1—Dec 1, 2007; WBS 1 is predecessor; Kansas HIE Commission)
3.1. Network with other states and national efforts to determine which standards and best practices to recommend/adopt (May 1—Dec 1, 2007; no predecessors; Kansas HIE Commission)
3.1.1. Establish networking process (email, web portal, or other networking approach) with other HISPC states plus Nebraska, Missouri, and Colorado
3.2. Share standards and best practices with the healthcare organizations in Kansas (May 1—Dec 1, 2007; no predecessors; Kansas HIE Commission)
3.2.1. Designate a task force to identify the standards and best practices of interest and import to privacy and security issues in sharing data
3.2.2. Develop a statewide web site for Kansas healthcare organizations to access information the above information
3.2.3. Establish a process for keeping the information on the web site current
3.3. Monitor national trends, frameworks, and initiatives concerning HIT and HIE, e.g., ANSI-HITSP, CCHIT, CHI, ONCHIT, NCVHS (Apr 1, 2007—Aug 30, 2008; WBS 1 is predecessor; HISPC Steering Committee, Kansas HIE Commission)

4. Develop model policies, procedures, and guidelines for the exchange of health information (May 1, 2007—Aug 30, 2008; WBS 1 is predecessor; Kansas HIE Commission)
4.1. Identify model policies and procedures (May 1—Dec 5, 2007; no predecessors; Kansas HIE Commission)
4.2. Identify model guidelines (May 1—Dec 5, 2007; no predecessors; Kansas HIE Commission)
4.3. Identify best practices for identification and authentication (May 1—Dec 5, 2007; no predecessors; Kansas HIE Commission)
4.4. Identify best practices to insure health information security (May 1—Dec 5, 2007; no predecessors; Kansas HIE Commission)
4.5. Identify Return on Investment (ROI) for HIT models for a variety of stakeholders security (May 1—Dec 5, 2007; no predecessors; Kansas HIE Commission)
4.6. Disseminate the models to healthcare organizations (Dec 7, 2007—Aug 30, 2008; WBS 4.1, 4.2, 4.3, 4.4 are predecessors; Kansas HIE Commission)
4.6.1. Post information on the statewide web site developed in WBS 3.2.2

5. Educate healthcare entities and the public about the benefits and processes of health information exchange (Dec 7, 2007—8/30/2008; WBS 1, 3.2, 4.1, 4.2, 4.3, 4.4 , 4.5 are predecessors; Kansas HIE Commission)
   5.1. Develop strategies and materials to educate healthcare organizations (Dec 7, 2007—Feb 28, 2008; no predecessors; Kansas HIE Commission)
      5.1.1. Identify experts and faculty for the educational offerings
   5.2. Provide workshops and/or webnairs to share technical capacity and best practices (July 1—Aug 30, 2008; WBS 5.1 is a predecessor; Kansas HIE Commission)
   5.3. Develop web page to enable sharing of information (Mar 1—May 5, 2008; no predecessor; Kansas HIE Commission) See WBS 3.2.2.
   5.4. Develop a Resource Center (a knowledge management and support strategy) for the stakeholders (Mar 1—May 5, 2008; WBS 3.0, 4.1, 4.2, 4.3, 4.4 , 4.5 are predecessors; Kansas HIE Commission)
      5.4.1. Collaborate with the University of Kansas Center for Healthcare Informatics for provision of this service
   5.5. Establish a stakeholders' network ((Mar 1—May 5, 2008; no predecessor; Kansas HIE Commission)
      5.5.1. Continue to validate the solutions and implementation plans developed in the HISPC project with stakeholders and consumers
6. Promote implementation of health information exchange (May 1, 2007—Oct 1, 2008; no predecessors; Governor's office, Kansas HIE Commission; key legislators)
   6.1. Design strategies to support collaboration between healthcare organizations and other stakeholders (exchange (May 1, 2007—Oct 1, 2008; WBS 1 is a predecessor; Kansas HIE Commission)
   6.2. Identify comparable HIT efforts in Missouri and engage key Missouri stakeholders (May 1—Dec 1, 2007; no predecessors; Kansas HIE Commission)

As the HIE Commission assumes responsibility for this multi-solution plan, more specific plans will be generated.

1. Summary of effective practice(s) to be instituted or barrier(s) to be mitigated or eliminated by the plan
   a. Most of the barriers relate to provider/organization/payer lack of knowledge, variable adoption of HIT, and supportive state legislation; these are to major foci of the plan
2. Planning assumptions and decisions
   a. The Governor continues to support HIE efforts
   b. The HIE Commission will begin the work within the timeframe specified in the plan
   c. The HIE Commission will assume responsibility for the plan
   d. The existence of independent pilot HIE projects indicates commitment from the stakeholders to support and engage in Kansas level imitatives
3. Project ownership and responsibilities (identify specific individual and/or organization names and titles): specified in the plan
4. Clearly defined project scope: specified in the plan
5. Identification of tasks required, organized by work breakdown structure: specified in the plan
6. Project timeline and milestones: specified in the plan

7. Projected cost and resources required: more study is needed to evaluate cost and resources depending on scope undertaken by governance structures created to advance HIT/HIE in Kansas
8. Means for tracking, measuring and reporting progress: the Kansas HIE Commission will identify these
9. Impact assessment on all affected stakeholders in the state (including small and rural providers): Kansas HIE Commission will conduct this assessment; the State of Kansas has conducted some assessments and these were described above
10. Feasibility assessment (only to provide any additional detail beyond the feasibility assessment documented in the Solutions Report): The plan is believed to be very feasible especially in light of the Governor making HIT/HIE a priority for the State and the timing to address these issues is right from a local, regional and national perspective.
11. Possible barriers that the implementation plan may face: Lack of knowledge and beginning implementations of information technology in the state are major barriers. However, the state and the various healthcare organizations involved in HISPC have committed to making the plan(s) work. Funding to provide support for the initiatives addressed in the plan could be a barrier.

V. Multi-state Implementation Plans

Implementation plans that require cooperation and collaboration by two or more states due to barriers with interstate implications should be documented in this section.

A. Multi-state strategy and coordination

List all states affected by and included in the plan. Describe the strategy for coordinating and overseeing the implementation of solutions affecting two or more states; identify responsible persons, lines of authority and communication, organizations or agencies involved, and staffing and other resources needed to manage the project

The states of Colorado, Nebraska, Oklahoma, and Missouri have been identified as possibly being affected by this plan since citizens of Kansas may seek care in these states due to proximity of healthcare providers. To date, Missouri is the only state that has been contacted and several similar projects are already underway.

Demonstration project that cross state lines are in place and will be monitored to determine outcomes and in particular ROI. These projects include Healthe Mid America, KC CareLink, InfoLinks and BC/BS Immunization registry.

Continued funding to support the advancement of HIT/HIE including education and outcomes studies is essential to the success of HIE.

B. Implementation plans for identified solutions

Implementation plans involving multiple states require project plans for completion.

The Kansas Implementation Plan is specified in the following multi-state plan that includes the work breakdown structure (with timeline, predecessors, and responsible persons in parentheses):

1. Currently, Kansas providers have exchanged patient level data through the Kansas Hospital Association in Kansas, Missouri, Colorado, and Nebraska to provide market share and benchmarking data for operational decision making. Critical markets to hospital providers are Denver, Colorado; Omaha, Kearney, and Lincoln, Nebraska; and Joplin and Kansas City, Missouri. The state databases have common definitions, layouts, and/or crosswalks to facilitate the data exchange. These contacts will be used to continue work in increasing data exchange.
2. Establish the Kansas and Missouri Immunizations Registry project which builds on each state's registries. (May 1—June 30, 2007; no predecessor; Kansas Immunization Registry, Missouri Immunization Registry, Kansas HIE Commission)
   2.1. Support the work of a task force working on a grant to support this project
3. Follow-up with the State of Nebraska, contacted at the Regional and National HISPC meetings, to develop a strategic plan for coordinating HIE efforts.

4.

Appendix A

Kansas HISPC Solutions Summary

Kansas HISPC Draft Solutions Summary

Domain 1: User and entity authentication

Solution 1.1: Development of a standardized definition and process to determine user identity and authentication at the level of patient, provider, payer, government, and other administrative persons/entities.

Solution 1.2: Require a multiple level process of authentication. At a minimum authentication should be a 2-factor process, i.e. ID, password, biometrics, etc.

Solution 1.3: An entity should be established that is responsible for the administration of a repository of user and entity IDs and authentication.

Domain 2: Access rights and controls

Solution 2.1: Every provider/organization should have a policy and set of procedures that

a. identify general roles or classes of individuals who will access information (smaller providers will need fewer classes)
b. identify levels of access for each identified role
c. details of how audit processes will be used to determine if policy and procedures are being used appropriately and how findings will be used to improve policy and procedures if necessary
d. details of enforcement of policy and procedures
e. explanation of the override to controls in an emergency situation

Solution 2.2: Technical controls for electronic access by role

Solution 2.3: Patient documentation of receipt of and education about policy and patients rights related to access by others to their record

Solution 2.4: Patient notification when audit identifies inappropriate access or use of record

Solution 2.5: No solutions details yet available in this domain for

a. Patient control of access to EHR by specific individuals
b. Patient access to record or audit trail of individuals who have accessed record

Domain 3: Patient and provider ID's and record locators

Solution 3.1: Determine best practices for identity validation/confirmation in compliance with NHIN framework. Institute these processes in Kansas.

Solution 3.2: Determine best practices for identifier assignment mechanisms in compliance with NHIN framework and NCVHS privacy and confidentiality recommendations. Provide guidance to Kansans through workshops and web-based resources.

Solution 3.3: Determine best practices for types of identification needed (*e.g.*, patient, provider, payer at personal and/or organizational level) depending on contexts and roles, consistent

with NHIN framework. Provide guidance to Kansans through workshops and web-based resources.

Solution 3.4: Determine best practices for education concerning identifying patients, providers, etc., consistent with NHIN framework and NCVHS privacy and confidentiality recommendations. Develop an innovation adoption strategy for assignment of identifiers. Share solution in workshops for both the public and professionals; provide guidance materials on state web site

Domain 4: Information transmission security

Solution 4.1: An ongoing educational and knowledge sharing effort that is available to a wide variety of stakeholders. The educational / knowledge program should be based around a general model of needed knowledge and organizational perspective as well as recognizing the anticipated transformation from a low-tech/low-HIE climate to a high-tech/full-HIE environment.

Solution 4.2: Monitor and audit stakeholders, including developing RHIOs, for use and compliance with identified national standards for security/privacy as well as exchange of data.

Solution 4.3: Identify and educate stakeholders on baseline expectations for network level security (e.g., SSL) and how transmission level security connects to HIPAA in a climate of internal / external health information exchange. Extend this education and compliance expectation to a climate that monitors compliance and encourages periodic changes in the security approach. Encourage network security enhancements that exceed the minimum expectation of 128 or 256 bit encryption.

Solution 4.4: Facilitate applied research through collaboration with the state' universities that is focused by an assessment of the unique climate found in a rural setting and rural stakeholders, such as Critical Access Hospitals.

Solution 4.5: Build or extend a web capability to include "best practice" documents such as business associate agreements.

Domain 5: Preserving integrity of stored information

Solution 5.1: Identity authentication and role-based access policies for record and field-level data creation, revision, update, deletion.

Solution 5.2: Complete, auditable and reversible revision history

Solution 5.3: Continuous fraud detection activities

Solution 5.4: No solution details yet available in this domain for cross-validation of information within or among multiple sources, *i.e.* data content audits. Training

Domain 6: Information systems activity audits

Solution 6.1: Complete, auditable information access logs, including reading, copying, printing or transmitting. (Use of multiple technologies will necessitate multiple types of logs.)

Solution 6.2: No solution details yet available in this domain for protecting information carried away from its source.

Solution 6.3: Periodic external audits of:

a. information access logs
b. tests of system "hardness" against attempted breaches
c. user compliance with data use agreements

Domain 7: Administrative and physical security safeguards

Solution 7.1: Statewide effort to create "learning communities" around the transformation of the healthcare system. These learning communities are collaborative ventures among regions, school districts, community colleges and universities.

Solution 7.2: Establish guidelines that coordinate with the current HIPAA security standard especially in the context of securing PHI within a repository. Original HIPAA security recommendations included encryption in this area and efforts should be made to return to this higher standard.

Solution 7.3: Develop education and "best practice" information / guidelines / practices that can be used by a facility to monitor and administer the devices on their networks

Domain 8: State law

Solution 8.1: State laws and regulations should be amended to coordinate with HIPAA to minimize confusion and misinterpretations.

Solution 8.2: Develop educational materials to address public misconceptions about HIPAA and the interpretation of state law with HIPAA.

Solution 8.3: Identify laws and regulations of other states to adapt as models for interstate and intrastate information exchange.

Domain 9: Information use and disclosure policies

Solution 9.1: Encourage development of federal HIPAA Safe Harbors policies to reduce legal exposure of providers who share protected health information.

Solution 9.2: Develop information use and disclosure policies which comply with state and federal laws to serve as models for the various stakeholders engaged in information exchange.

Solution 9.3: Develop educational materials to encourage the implementation of information use and disclosure policies.

Appendix B

Kansas HIT/HIE Policy Initiative Report:
Barriers and Proposed Solutions to HIE in Kansas

Kansas HIT/HIE Policy Initiative
Barriers and Proposed Solutions to HIE in Kansas

The Kansas HIT/HIE Clinical Workgroup, a multi-stakeholder workgroup formed as part of the statewide HIT/HIE Policy Initiative commissioned by the Governor's Health Care Cost Containment Commission, convened between August 2006 and January 2007. One of the charters of the Clinical Workgroup was to identify barriers to interoperable health information exchange and propose solutions to those barriers. The following report outlines the identified barriers and proposed solutions. Links between identified barriers and solutions are not necessarily exclusive to one another, and featured strategies may play a role in the resolution of more than one noted issue. It should also be noted that this document reflects a static picture of a work in progress, and the status of both barriers and solutions should prompt frequent re-evaluation as they change over time.

- Limited resources: time, people, and money.

  Challenges remain with identifying funding sources for HIT to create databases, build retrieval and interchange systems, and make information available for electronic exchange across organizations. Staff time to perform HIT functions and staff expertise in HIT and HIE systems is limited across both public and private health care organizations. This is especially true in rural areas, where recruitment of highly skilled "computer savvy" personnel is difficult. Radical differences in how workflow, productivity, and utility of an HIT system are defined between providers, administrators, IT personnel, and policymakers leads to intense competition for scarce resources.

  Proposed Solution: Provide education about HIT and HIE.

  The provider community, the healthcare industry, medical consumers, policy makers, and employers must be educated on HIT/HIE and the benefits of HIE. These efforts will be key to driving policy change, fiscal programs, and public acceptance of HIE systems. All parties participating in HIE development must communicate the needs for end-user utility to system designers and administrators. Successful demonstration projects with well-documented outcomes will lead to the identification of HIE champions throughout Kansas.

- Balancing privacy and health care worker access to protected health information.

  Ensuring privacy and security of health care information that would be available with HIT/HIE. Providers specifically cited concerns about health care employees accessing personal health information outside of "need to know" operations.

  Proposed Solution: To be developed under the Privacy and Security Collaborative.

- Lack of interoperable systems.

  There are very few systems currently in use within health care organizations that are interoperable. This problem exists both within and across organizations. Representatives from public health especially noted they have multiple unlinked databases.

  Proposed Solution: Require standard universal interface software in vendor contracts.

Once technical standards are established, the standards must be disseminated to both the provider and health care community. Model contracts and work agreements describing these agreed-upon standards might be circulated to likely purchasers for use in their own procurement of electronic systems. Busy providers are freed from attempting to describe the technical parameters of their individual HIE interface while ensuring that purchased products will be compatible with regional HIE systems.

Proposed Solution: Develop and use common HIT and HIE terminology.

Speaking a common language, both colloquially (HIE, HIT, et al) and technically (HL7, PHIN, etc.) is key to developing consensus on standards and a shared understanding of the capabilities and limitations of HIE systems. A priority project of the next phase of HIE development should be the development of a dictionary of standard terminology to be used throughout the effort. This should be incorporated into an education/communication plan.

Proposed Solution: Insure that Kansas HIE systems remain "open."

HIT system designs tend to be static, in that they tend to "close the door" to new users and new sources of information. Regional HIE systems in Kansas cannot be thought of as an end product unto itself. Systems must be designed to remain "open" to other current unrelated systems, as well as be able to integrate easily with future systems, through aggressive promotion of interoperability standards and flexibility within these standards to reflect changes in technology and use.

- Decentralized health care and public health information networks.

The landscape of health and health care data systems is littered with stand-alone systems unable to communicate with one another. While this might be expected given the proprietary nature of the private sector, this is true of the public sector as well. Public health representation noted that the decentralized nature of the Kansas public health system contributes to the lack of intra- and inter-organizational interoperability, common systems, and the state's ability to require standardization.

Proposed Solution: Determine if legislation is needed to address disparate databases.

Proprietary business models often feature deliberate "closeting" of data and are often mutually exclusive of one another. Consequentially there may be a lack of incentives to cause companies to abandon this model in favor of a more open and interactive format. Legislation enabling HIE, mandating that electronic systems are compatible with interoperability standards, or offering financial incentives to promote data exchange may be required to establishing a solid HIE model for the state.

- High percent of Kansas health care providers currently lack HIT.

75% of Kansas physician providers currently do not have health information technology applications functioning in their primary practice setting. Potential impacts upon provider workflow within the practice, resulting in a real or perceived loss of productivity, constitute a major barrier to HIT acceptance. The experience of other providers with HIT systems designed to facilitate administrative rather than clinical workflow contributes to this conceptual obstacle. Acceptance of HIT systems is not helped by the often radical differences in how workflow, productivity, and utility of an HIT system are defined between providers, administrators, IT personnel, policymakers, and purchasers. Getting these providers to accept any HIT system is necessary to practice management and a prerequisite to the deployment of an effective and comprehensive HIE system.

Cultural inertia also serves as a barrier to provider acceptance of HIT. Given an overall perception that physicians are generally able to manage their practices in a quality and cost-efficient manner, providers may feel little sense of urgency in establishing or updating HIT systems. The rapid pace of change in HIT architectures and capabilities also serves as a structural disincentive for immediate adoption of an HIT system when the new and improved version is perpetually a few months away.

Proposed Solution: Build physician leadership around HIE across state.

A large portion of physician practices in Kansas operate as a "Mom and Pop" industry, with small practices populating the medical landscape of the state. Utilization of health care remains, in large part driven by physicians; and they will drive the system as a whole towards HIE and HIT and become active leaders in the effort when they see distinct benefits from it. Physician leadership can be promoted through the use of workshops and toolkits explaining HIE, research and practical models documenting a positive "return on investment" (improving the financials or quality of care) within the practice, encouraging physicians to champion the cause of HIE, and enlisting close support from provider organizations such as KMS, KOMA, and KAFP.

Proposed Solution: Demonstrate value to providers through both financial and quality measures.

Providers will desire to use HIE systems, and demand that off-the-shelf electronic systems be compatible with larger HIE exchanges, when both the cost-efficiency and the positive impact on quality of care have been demonstrated. State promotion of pilot projects, such as the Medicaid Community Health Record pilot in Sedgwick County, will help to demonstrate these benefits.

Proposed Solution: Incremental change.

Successful models for HIE have often been incremental. For example, a Cincinnati model started with fax servers and over time moved to a fully electronic exchange). Implementation of HIE programs in Kansas should be considered incremental, focusing on the baseline technical capabilities of the majority of participants within a regional HIE exchange and leveraging existing initiatives or resources. Incremental progress eases transitions to a fully electronic exchange and minimizes the chances for error with radical changes in systems and processes.

Proposed Solution: Evaluating workflow impacts of HIE systems

Regional HIE systems throughout Kansas will be not used unless workflow practices are taken into account. In designing user interactions with these systems, workflow and business practice models of all potential end-users must be evaluated and taken into account. Special attention should be paid to the workflow impacts upon providers; without their acceptance, the clinical utility of the system is absent.

- Manual and duplicative data entry.

Layering new HIT and HIE systems on top of existing systems in both public and private organizations often requires manual entry of both old and current data. Many organizations do not have staff available to dedicate to this manual entry, especially when it is a duplicative record. The deployment of the Kansas WebIZ program is illustrative of the problems inherent in data

acquisition and data base population when current systems do not integrate with new ones, and use of the newer and more optimal system require dual entry and increases workload.

Proposed Solution: Use existing data sources for medication, procedure, office encounter, and diagnosis history.

As noted, the state already holds several types of claims-based data, including KHIIS, the KHA Discharge Database, Medicaid, and State Employee Health Plan data. Diagnostic, procedure, and product codes may be extracted from these existent databases to serve as a rough model for a fully integrated HIE system. Noting that the state already holds this data significantly eases acquisition issues inherent in the initial stages of HIE development. Private sector resources which might serve as test beds include prescription management programs such as SureScripts.

- Decreased provider revenues from HIE use.

Physicians commented that it will be difficult to convince others to join the HIE efforts as long as it is perceived to potentially slow practice operations. If providers are asked to spend their own money for HIT and HIE applications which might lead to an inadvertent slow down of operations (and hence less patient flow and less revenue), they will not join. Even if the slowdown might be short term and based on a "learning curve," office turnover means that the problem remains relatively constant. Providers should not be asked to purchase into legacy systems, especially when proposed standards for HIE systems remain in flux.

Proposed Solution: Confirm the financial stability of a clinical practice after HIE implementation through demonstration projects.

While the general process of educating the health care community regarding HIE has been discussed, special focus should be placed on financial and quality measures (in the context of quality of care, not of compliance to standards) in presenting HIE material to health care providers. Where financial stability for a clinical practice (including opportunity costs) is unable to be achieved in HIE implementation demonstration projects, targeted incentives should be considered to promote HIE use.

- Rural composition of population

There are 31 frontier counties in Kansas where much of the health care for complex chronic conditions is not delivered locally. HIE systems will be required to interchange over long distances and with multiple systems that may span regions or even states.

Proposed Solution: Leverage existing infrastructure in Kansas.

Kansas has already begun facing the geographic challenges posed above. Required collaboration by the over 80 Critical Access Hospitals and their community hospital partners throughout the state has already established a large number of relationships, and common patterns of regional medical referral suggest an underlying order to patient flow and potential record exchange. The Kan-Ed network allows hospitals to connect to the network, but hospitals have been slow to join the network, and physician clinics and other health care providers are prohibited, by statute, from connecting to Kan-Ed. Facilitating greater hospital participation and enabling additional providers to connect to the Kan-Ed network would likely accelerate rural implementation of HIE.

- Poor "system to system" sharing.

Data sharing relationships across health care organizations are poorly developed. There is a competitive environment that must be overcome. This is often seen in different organizations

whose business operations occur within the same metropolitan area and who are competing for the same consumer dollar. Competitive business models must be broken down and all parties recognize that HIE favors the business development of all.

Proposed Solution: Kansas models provide precedents for requiring submission to health care databases.

Claims databases often reside in private, proprietary hands and may be held out of an HIE effort unless mandated to do so. In Kansas, precedents already exist for the legislative requirement of claims databases to submit information to the state (KHIIS) or for the voluntary submission of claims data to state agencies (the Kansas Hospital Association Discharge Database, held by KDHE).

- Current business models do not support HIE.

Proprietary business models often feature deliberate "closeting" of data and are often mutually exclusive of one another. Doing so helps to maximize revenue for individual products, but does not promote interoperability or the free exchange of data. There are no current incentives to cause companies to abandon this business model in favor of a more open and interactive format.

Proposed Solution: Leverage current HIE in Kansas.

Infrastructure development should utilize the efforts of existing HIE in an effort to minimize duplication. Current HIE projects between employers in the Kansas City metro area (Healthe), between KDHE, Kansas City metropolitan health departments, and Kansas City area employers (InfoLinks), and between Medicaid and provider practices in Wichita (Community Health Record Pilot) serve as examples for other regions of Kansas.

Appendix C

Kansas HIE Commission Announcement

KANSAS

OFFICE OF THE GOVERNOR — KATHLEEN SEBELIUS, GOVERNOR

For Immediate Release
February 7, 2007

Nicole Corcoran, Press Secretary
785.368.8500

Sebelius appoints Health Information Exchange Commission

Technology has potential to lower health costs, improve quality

Technology has the potential to help lower health care costs, while at the same time improving quality and reducing errors.

That's why Governor Kathleen Sebelius today announced the creation of the Health Information Exchange (HIE) Commission, a group designed to bring providers and stakeholders together to advance the use of information technology in health care.

"We have a real opportunity to use technology to get a handle on the administrative costs that eat up 30 cents of every dollar spent on health care. Even something as simple as a health insurance card that can be swiped through a card reader instead of copied has the potential to reduce costs and cut down on billing mistakes," said Sebelius.

"When you also consider the opportunities to reduce medical errors, it's clear that we need to bring these new technologies into more widespread use," she continued.

The HIE Commission will work to advance the recommendations of the HIE workgroups created through the statewide health information technology and health information exchange policy initiative. That initiative was created by the Governor's Health Care Cost Containment Commission, which sought to identify ways to reduce administrative costs in health care.

The new Health Information Exchange Commission will include representatives of the provider community, consumers, business community, health plans, government, information technology experts and health policy experts. They will take a public/private approach to advancing the use of information technology and ensuring patients' private health information is protected and secure.

The new HIE Commission will further the work of the Health Care Cost Containment Commission by seeking opportunities to expand the initiatives and implement the recommendations of the previous commission including efforts to standardize credentialing procedures for physicians joining health plan and hospital networks, developing an advanced ID card project, and seeking ways to promote the electronic exchange of health information while assuring the privacy and security of that information. The HIE Commission will coordinate and focus the state's continuing efforts to capitalize on the advantages of technology to achieve health care cost effectiveness and quality.

Members of the HIE Commission include:

Co-Chairs:
Jeff Ellis, Lathrop and Gage
Karen Braman, Preferred Health Systems

Members:
Tom Bell, Kansas Hospital Association
Jennifer Brull, MD, Prairie Star Family Practice
Helen Connors, KU Center for Healthcare Informatics
Joe Davison, MD, West Wichita Family Physicians
Diana Hilburn, Via Christi Health Systems, Inc.
Jackie John, RN, Great Plains Health Alliance
Maren Turner, AARP Kansas
Ken Mishler, Kansas Foundation for Medical Care
Marci Nielsen, Kansas Health Policy Authority
Sandy Praeger, Kansas Insurance Commissioner
Howard Rodenberg, Kansas Dept. of Health and Environment
Kristi Schmitt, ARNP, Finney County Health Department
Bob St. Peter, MD, Kansas Health Institute
Bill Thornton, MGP Ingredients
Bill Wallace, Blue Cross Blue Shield Kansas

# # #

CAPITOL BUILDING, ROOM 212S, TOPEKA, KS 66612-1590
Voice 785-296-3232 Fax 785-296-7973 http://www.governor.ks.gov